

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey was conducted on 11/6/14 was conducted by the Indiana State Department of Health in Accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/15/14</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230</p> <p>Surveyor: Brett Overmyer, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Dungarvin Indiana LLC, was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in the living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K01S046	<p>Calculation of the Evaluation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.16.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electric outlets in the basement living room area were provided with cover plates. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. Article 370-25, Covers and Canopies, states "In completed installations each box shall have a cover, faceplate or fixture canopy." This deficient practice could affect one client, staff, and visitors.</p>	K01S046	The two exposed electric outlets in the basement living room area were provided with cover plates on 12/23/14. This will be verified by the maintenance supervisor and Program Director/QIDP by 01/09/15. All staff working in the home will be retrained by 01/09/15 regarding this life safety code standard and the expectation that they are to report maintenance issues in a timely manner during their shift when the need is discovered. Going forward, the Lead Direct Support Professional will complete a monthly site risk checklist. The checklist involves conducting an environmental walk-thru of the	01/09/2015

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K01S147	<p>Findings include:</p> <p>Based on observation on 12/15/14 at 11:00 a.m., with the Direct Support Professional (DSP), the basement living area had two electrical wall outlets not covered with a cover plate. The DSP acknowledged the aforementioned deficiencies.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on observation, record review and interview, the facility failed to provide and to periodically instruct staff of a plan</p>	K01S147	<p>facility, one area on the checklist is to ensure all outlets have cover plates and that they are in good repair. If a need for repair is identified, the Lead DSP is required to complete an immediate maintenance request and forward the request to the maintenance supervisor and Program Director/QIDP. The monthly site risk checklist is reviewed monthly by the Program Director/QIDP. It is also completed by the QIDP on a quarterly basis for ongoing quality assurance.</p> <p>All staff at the facility receive introductory and ongoing training on the emergency policy and</p>	01/09/2015

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	<p>for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the home. Further, NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 edition at 6-5.2.1 says the protection plan should include the following features:</p> <p>(a) A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes.</p> <p>(b) A fundamental knowledge of fire growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes.</p> <p>This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on interview on 12/15/14 between 10:50 a.m. and 11:30 a.m. with the Direct Support Professional (DSP), there was documentation of a protection plan and there was documentation of staff instruction on a protection plan located in the home at the time of this visit, however the DSP did not know how to silence the alarm, reset the pull station and reset the alarm. The DSP stated the fire alarm did not ring into a central</p>		<p>related procedures. All staff at the facility will be retrained on the attached Emergency Policy and the attached Emergency Plan for the group home by 01/09/2015. In addition, all staff will be retrained on how to run an emergency fire drill, including but not limited to: how to silence the alarm, reset the pull station, and reset the alarm. The maintenance supervisor will create an instruction protocol based on the NOBI manual and the protocol will be posted at the pull station in the facility. All staff will be retrained on this instruction protocol by 01/09/2015. Going forward, all staff will receive ongoing facility-based emergency training on a bimonthly basis (every 60 days). Copies of the training records will be maintained in the Emergency Binder at the home.</p>				

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K01S155	<p>dispatch station, however the Merrillville Fire Department arrived on the scene after the alarm was tested, stating they had received an alarm. The DSP acknowledged the aforementioned deficiency.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8</p> <p>Findings include:</p> <p>Based on observation and record review on 12/15/14 between 10:50 a.m. and 11:30 a.m., with the Direct Support Professional (DSP), no documentation of a fire watch policy was found. The DSP acknowledged that there was no documentation of a policy for a fire</p>	K01S155	<p>All staff at the facility receive introductory and ongoing training on the emergency policy and related procedures. All staff at the facility will be retrained on the attached Emergency Policy and the attached Emergency Plan for the group home by 01/09/2015. In addition, all staff will be retrained on the expectations and location of the fire watch protocol (within the facility emergency plan) and the attached fire watch worksheets. Going forward, all staff will receive ongoing facility-based emergency training on a bimonthly basis (every 60 days). Copies of the training records will be maintained in the Emergency Binder at the home. In addition, copies of the emergency policy, facility</p>	01/09/2015	

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	<p>watch. The DSP contacted the Residential Manager via telephone at 11:15 a.m. Based on telephone interview, the Residential Manager indicated she was not even aware a POC had been submitted. It was explained to her that a POC had been submitted which stated that staff would be trained and all written policies for the fire watch were to be placed in the emergency binder at the facility.</p> <p>This deficiency was cited on 11/6/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>emergency plan, and fire watch worksheets will be located in the emergency binder by 01/09/2015.</p>		